SECTION 2B

Physician services

RECOMMENDATIONS

2B The Congress should update payments for physician services in 2011 by 1.0 percent.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 1 • ABSENT 1

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(For additional recommendations on a fee schedule adjustment for primary care, see text box on pp. 88–89.)

SECTION 2B

Physician services

Section summary

Physician services include office visits, surgical procedures, and a broad range of other diagnostic and therapeutic services furnished in all settings. In 2008, fee-for-service (FFS) Medicare spent about $61 billion on physician services, accounting for 13 percent of total Medicare spending. Among the 950,000 providers registered to bill Medicare for physician services, approximately 570,000 are physicians who are actively billing Medicare. The remainder—who accounted for approximately 10 percent of Medicare's 2008 fee schedule spending—includes other health professionals such as chiropractors, nurse practitioners, and physical therapists. Almost all FFS Medicare beneficiaries (97 percent) received at least one physician service in 2008.

In this section

- Are Medicare payments adequate?
- How should Medicare payments change in 2011?
- Accuracy and equity of payment for physician services

Assessment of payment adequacy

Our analysis of payment adequacy for physician services in Medicare FFS finds that most indicators (discussed below) are positive and stable, suggesting that most beneficiaries can obtain physician care on a timely basis. Therefore, the Commission recommends that Medicare's payment for physician services be increased by 1.0 percent in 2011.

Beneficiaries' access to care—Overall, beneficiary access to physician services is good and better than that reported by privately insured patients age 50 to 64. For 2009, most beneficiaries reported that they could get timely physician appointments. Among the small share of beneficiaries looking for

a new physician, most could find one without major problems; however, finding a primary care physician was more difficult than finding a specialist. As in past surveys, racial and ethnic minorities in both the Medicare and privately insured populations were more likely to experience access problems.

While access is good on a national level, beneficiaries in certain market areas may be experiencing more access problems due to factors unrelated to Medicare payment rates, such as relatively rapid population growth. Although a small share of beneficiaries report major problems finding a primary care physician, the issue is a serious concern not only to the beneficiaries but also to the functioning of our health care delivery system. The Commission has made recommendations in previous reports to promote primary care services through targeted payment increases and the testing of medical home models of care.

Other indicators of access include supply of providers serving Medicare beneficiaries and changes over time in the volume of services provided.

- ***Supply of providers***—A 2008 survey conducted by the Center for Studying Health System Change found that most physicians (74 percent) accepted all or most new Medicare patients in their practice (Boukus et al. 2009). Acceptance rates for privately insured patients were higher. Physicians in our focus groups stated that acceptance of privately insured patients varies by specific health plan.
- ***Volume of services***—Service volume per beneficiary continued to grow in 2008. Overall volume (reflecting both service units and intensity) grew 3.6 percent per beneficiary. This rate was higher than the 2007 rate of 2.9 percent. Growth varied among broad categories of services, but all were positive.

Quality of care—Most claims-based indicators for ambulatory quality that we examined for the elderly improved slightly or were stable from 2006 to 2008.

Medicare payments and providers' costs—Medicare's payment for physician services in 2008 averaged 78 percent of private insurer payments. This percentage marks a generally stable ratio over the last decade.

Accuracy and equity of payment for physician services

The Commission has consistently raised concerns about mispricing of services in the physician fee schedule and the inequity of a payment system that financially rewards specialties that can generate volume and revenue more readily than others. In this chapter, we discuss plans for future work on these issues. ■

Background

Physician services include office visits, surgical procedures, and a broad range of other diagnostic and therapeutic services. They are furnished in all settings, including physician offices, hospitals, ambulatory surgical centers, skilled nursing facilities, other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Among the 950,000 providers registered to bill Medicare for physician services, approximately 570,000 are physicians who are actively billing Medicare.[1] The remainder—who accounted for approximately 10 percent of Medicare's 2008 fee schedule spending—includes limited licensed practitioners and other health professionals such as chiropractors, nurse practitioners, and physical therapists.

Physician services are billed to Medicare Part B. Medicare fee-for-service (FFS) payments for physician services totaled $61 billion in 2008, accounting for about 13 percent of Medicare's overall spending (Boards of Trustees 2009). In the decade 1999 through 2008, Medicare spending per beneficiary on physician fee schedule services grew 72 percent. Almost all FFS Medicare beneficiaries (97 percent) received at least one physician service in 2008.

In the FFS program, Medicare pays for physician services according to a fee schedule that lists services and their associated payment rates. The fee schedule assigns each service a set of three relative weights (physician work, practice expense, and professional liability insurance) intended to reflect the typical resources needed to provide the service. These weights are adjusted for geographic differences in practice costs and multiplied by a dollar amount—the conversion factor—to determine payment amounts. In general, Medicare updates payments for physician services by increasing or decreasing the conversion factor. For further information, see MedPAC's *Payment basics: Physician services payment system.*[2]

By law, the update of the physician fee schedule conversion factor is determined by a formula—the sustainable growth rate (SGR)—set forth in the Balanced Budget Act of 1997. It ties payment updates to four factors: changes in input costs, changes in Medicare FFS enrollment, changes in the volume of physician services relative to growth in the national economy, and changes in law and regulation. Although the SGR formula has yielded negative updates in recent years, the Congress has overridden the formula and taken a series of legislative actions to prevent payment reductions since 2003. The SGR formula continues to call for negative updates for several upcoming years, stemming from avoided cuts on top of continued volume growth.

The Commission is not satisfied with the current physician payment update mechanism. The existing SGR formula does not provide incentives for individual physicians to control volume growth, and it is inequitable across physicians. In previous reports, the Commission has examined several alternative approaches for updating physician payments and made suggestions for improving the accuracy of Medicare's payments, creating incentives for physicians to provide better quality of care, coordinating care across settings, and using resources judiciously (Medicare Payment Advisory Commission 2007a).

Are Medicare payments adequate?

Our analysis of payments for physician services in FFS Medicare shows that, in the aggregate, payments through 2009 are adequate. Our assessment examines several indicators: beneficiary access to physician care, including rates of physicians participating with Medicare and taking assignment and changes in the volume of services provided; quality of care; and Medicare reimbursement levels compared with those in the private sector. In the most recent years for which we have data, each indicator was positive or stable with respect to payment adequacy. Unlike our payment adequacy assessments of other providers, such as hospitals, we cannot look at financial performance of physicians directly because they are not required to report their costs to Medicare.

Beneficiaries' access to care: Generally good with relatively few problems reported

Physicians are often the most important link between Medicare beneficiaries and the health care delivery system. Our analysis of the 2007 Medicare Current Beneficiary Survey shows that about 85 percent of noninstitutionalized beneficiaries report that a doctor's office or clinic is their usual source of care. Beneficiary access to physicians, therefore, is an important indicator to monitor when assessing Medicare's payment adequacy. Our analysis of access to physician services focused on indicators from several sources, including patient surveys, physician

surveys, beneficiary focus groups, physician focus groups, and claims data.

The Commission's 2009 patient survey shows that, overall, access is good, but primary care continues to be a concern

To obtain the most current access measures possible, the Commission sponsors a telephone survey each year of a nationally representative, random sample of two groups of people: Medicare beneficiaries age 65 or older and privately insured individuals age 50 to 64. For our 2009 survey (conducted from August through October), we increased the sample size to 4,000 in each group (totaling 8,000 completed interviews including an oversample of minority respondents) to increase statistical power.[3] By surveying both groups of people—privately insured individuals and Medicare beneficiaries—we can assess the extent to which access problems, such as delays in scheduling an appointment or difficulty in finding a new physician, are unique to the Medicare population.[4]

Results from our 2009 survey indicate that most beneficiaries have reliable access to physician services, with most reporting few or no access problems. Most beneficiaries are able to schedule timely medical appointments and find a new physician when needed, but some beneficiaries experience problems, particularly for primary care. Moreover, Medicare beneficiaries reported similar or better access than privately insured individuals age 50 to 64.

On a national level, this survey does not find widespread physician access problems, but certain market areas may be experiencing more access problems due to factors unrelated to Medicare—or even private—payment rates, such as relatively rapid population growth. Moreover, although a relatively small share of beneficiaries report major problems finding a primary care physician, this issue is a serious concern not only to the beneficiaries but also to the functioning of our health care delivery system. Media attention on this matter is understandable. The Commission has made recommendations in previous reports to promote primary care services through targeted payment increases and the testing of medical home models of care.

Most beneficiaries are getting timely appointments

Most Medicare beneficiaries have one or more doctor appointments in a given year. Therefore, one access indicator we examine is their ability to schedule timely appointments. In the 2009 survey, most Medicare beneficiaries (77 percent) and most privately insured individuals age 50 to 64 (71 percent) reported "never" having to wait longer than they wanted to get an appointment for routine care (Table 2B-1). Another 17 percent of Medicare beneficiaries reported that they "sometimes" had to wait longer than they wanted for a routine appointment, compared with 22 percent of privately insured individuals. The differences between the Medicare and privately insured populations in their "never" and "sometimes" response rates were statistically significant, suggesting that, on average, Medicare beneficiaries were more satisfied with the timeliness of their routine care appointments.

As expected, rates of getting timely illness- and injury-related appointments were better than rates for routine care appointments. Again, Medicare beneficiaries were less likely than privately insured individuals to report problems getting timely illness or injury appointments. Among those who had an appointment for an illness or injury, 85 percent of Medicare beneficiaries and 79 percent of privately insured individuals said they "never" experienced a delay, while 11 percent of Medicare beneficiaries reported "sometimes" having to wait longer than they wanted, compared with 17 percent of privately insured individuals. These differences are statistically significant, suggesting that, on average, Medicare beneficiaries were less likely than privately insured individuals to encounter delays for illness and injury appointments.

Beneficiaries' appointment access in 2009 varied by race, with minorities more likely than whites to report access problems (Table 2B-2, p. 74). This difference was seen for both the Medicare and the privately insured populations. For example, white Medicare beneficiaries (78 percent) were significantly more likely than minority beneficiaries (72 percent) to report never waiting longer than they wanted for routine care appointments. Among the privately insured population, whites (72 percent) were significantly more likely than minority individuals (67 percent) to report never waiting longer than they wanted for routine care appointments. The trend was similar for illness and injury appointments. Within our sample, access problems were more frequent for minorities with private insurance than for those with Medicare, but few of these differences were statistically significant. Finding disparities in access between whites and minorities is consistent with recent research conducted by the Center for Studying Health System Change (HSC). On the basis of a national

TABLE 2B–1

Trends in access to physicians for Medicare beneficiaries age 65 or older and privately insured persons age 50 to 64 remain stable across years, 2009

	Medicare (age 65 or older)				Private insurance (age 50–64)			
Survey question	**2006**	**2007**	**2008**	**2009**	**2006**	**2007**	**2008**	**2009**
Unwanted delay in getting an appointment: Among those who needed an appointment, "How often did you have to wait longer than you wanted to get a doctor's appointment?"								
For routine care								
Never	75%*	75%*	76%*	77%*	69%*	67%*	69%*	71%*
Sometimes	18*	18*	17*	17*	21*	24*	24*	22*
Usually	3*	3	3*	2*	5*	4	5*	3*
Always	3	3	2	2	4	3	2	3
For illness or injury								
Never	84*	82*	84*	85*	79*	76*	79*	79*
Sometimes	11*	13*	12*	11*	15*	17*	16*	17*
Usually	2	3	1	2	2	3	2	2
Always	1*	2	1*	1	2*	3	2*	2
Looking for a new physician: "In the past 12 months, have you tried to get a new primary care doctor?"								
Yes	10	9	6	6	10	10	7	8
No	89	91	93	93	90	90	93	92
Getting a new physician: Among those who tried to get an appointment with a new physician, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it…"								
Primary care physician								
No problem	76	70*	71	78	75	82*	72	71
Small problem	10	12	10	10	15	7	13	8
Big problem	14	17	18	12*	10	10	13	21*
Specialist								
No problem	80	85	88	88	83	79	83	84
Small problem	7	6	7	7	9	11	9	9
Big problem	11	9	4	5	7	10	7	7
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?" (Percent answering "Yes")	8*	10*	8*	7*	11*	12*	12*	11*

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 2,000 in years 2006 and 2007, 3,000 in 2008, and 4,000 in 2009. Sample sizes for individual questions varied.
*Indicates a statistically significant difference between the Medicare and privately insured samples in the given year at a 95 percent confidence level.

Source: MedPAC-sponsored telephone surveys, conducted August–September 2006, 2007, 2008, and 2009.

TABLE 2B–2

Access to physician care is similar or better for Medicare beneficiaries compared with privately insured individuals, but minorities in both groups report problems more frequently, 2009

	Medicare (age 65 or older)			Private insurance (age 50–64)		
Survey question	**All**	**White**	**Minority**	**All**	**White**	**Minority**
Unwanted delay in getting an appointment: Among those who needed an appointment, "How often did you have to wait longer than you wanted to get a doctor's appointment?"						
For routine care						
Never	77%*	78%*†	72%*†	71%*	72%*†	67%*†
Sometimes	17*	17*	18*	22*	22*	23*
Usually	2*	2	2	3*	3	4
Always	2	2†	4†	3	2†	5†
For illness or injury						
Never	85*	86*†	81*†	79*	80*†	75*†
Sometimes	11*	11*	11*	17*	17*	19*
Usually	2	1†	3†	2	2	2
Always	1	1†	2†	2	1†	3†
Looking for a new physician: "In the past 12 months, have you tried to get a new primary care doctor?"						
Yes	6	6*	8	8	8*	8
No	93	94	92	92	92	92
Getting a new physician: Among those who tried to get an appointment with a new physician, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it…"						
Primary care physician						
No problem	78	82*	69	71	70*	69
Small problem	10	7	17	8	8	11
Big problem	12*	11*	12	21*	22*	19
Specialist						
No problem	88	91†	75†	84	86†	73†
Small problem	7	5†	13†	9	9	11
Big problem	5	4†	11†	7	5†	16†
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?" (Percent answering "Yes")	7*	6*†	9*†	11*	10*†	13*†

Note: Numbers may not sum to 100 percent due to rounding. Missing responses ("Don't Know" or "Refused") are not presented. Overall sample size for each group (Medicare and privately insured) is 4,000. Sample sizes for individual questions varied.
*Indicates a statistically significant difference between the Medicare and privately insured samples in the given year at a 95 percent confidence level.
†Indicates a statistically significant difference by race within the same insurance coverage category in the given year at a 95 percent confidence level.

Source: MedPAC-sponsored telephone surveys, conducted August–September 2006, 2007, 2008, and 2009.

physician survey, the authors found that physicians with a higher share of minorities in their practice were more likely to report difficulties obtaining referrals to specialists for their patients (Reschovsky and O'Malley 2008). Physicians attributed such problems to the fact that many of their patients were uninsured or had insurance coverage that posed access barriers rather than to an inadequate supply of qualified specialists in the area.

Relatively few Medicare and privately insured patients sought a new physician, but of those who did, some experienced access problems

Our survey also monitors the two sample groups' need and ability to find a new physician. As in previous years, relatively few survey respondents reported that they tried to get a new primary care physician or specialist in 2009. This finding suggests that most respondents were either satisfied with their current physician or did not have a health event that made them search for a new one. Specifically, 6 percent of Medicare beneficiaries and 8 percent of privately insured individuals reported that they looked for a new primary care physician in the preceding year; a higher percentage (14 percent of Medicare beneficiaries and 19 percent of privately insured individuals) reported seeking a new specialist (not shown in table).

We found that, across income categories, Medicare beneficiaries appear equally likely to be looking for a new primary care physician (not shown in table). In contrast, among the privately insured population (age 50–64) those with lower incomes were more likely to report looking for a new primary care physician during the year. This situation may reflect more frequent job changes among lower income, privately insured individuals that lead to changes in insurance and applicable physician networks.

Of the 6 percent of Medicare beneficiaries who looked for a new primary care physician in 2009, 22 percent reported problems finding one—10 percent characterized the problem as "small" and 12 percent reported it as "big." Though reports of "big" problems in our sample have declined slightly, the 2009 rates are not significantly different from those found in our 2008 survey. Although the number of beneficiaries reporting any problem corresponds to less than 2 percent of the total Medicare population (22 percent of the 6 percent of beneficiaries looking for a new primary care physician), the problems these beneficiaries face can be distressing and are often featured in local and national media reports. It is also important to note that such media accounts typically report similar problems for privately insured individuals. For 2009, among patients looking for a primary care physician, Medicare beneficiaries were less likely to report a "big problem" than privately insured individuals.

Because several recent media reports have misstated the numbers that we present in this annual chapter, we want to emphasize that the percentage of beneficiaries and privately insured people reporting problems comes from a subset of those who indicate that they were, in fact, looking for a new physician or tried to get an appointment in the last year. Survey respondents who did not look for a new physician or did not try to get a physician appointment were not asked about related problems. Thus, the rates of patients reporting problems refer only to those people to whom the question applies and not to the Medicare or privately insured population at large. Accordingly, as stated earlier, among the 6 percent of Medicare beneficiaries reporting that they looked for a new primary care physician in the preceding year, those reporting that they experienced either "big" or "small" problems correspond to less than 2 percent of the total Medicare population.

As in previous years, we found that beneficiaries seeking a new specialist were less likely to report problems than those seeking a new primary care physician. Among those looking for a new specialist, 88 percent of Medicare beneficiaries reported "no problem" finding one in 2009, compared with 84 percent of privately insured individuals. Also, the rate of those with a "big problem" finding a specialist was lower (but neither is statistically significant) for Medicare beneficiaries than for privately insured individuals. More Medicare beneficiaries and privately insured individuals reported seeking a new specialist than a new primary care physician. These 2009 results are consistent with the findings in the 2008 and 2007 surveys (Table 2B-1, p. 73).

Our survey reveals some differences between minorities and whites in reported ease of finding a new physician (Table 2B-2). Among Medicare beneficiaries, we found a statistically significant difference in the share of whites (4 percent) and minorities (11 percent) who reported "big problems" finding a specialist. This finding mirrored the responses of privately insured individuals (Table 2B-2). Differences between whites and minorities in reported ease of finding a new primary care physician were not statistically significant in the Medicare population.

More specific analysis by race and ethnicity shows few significant differences between white and African American Medicare beneficiaries or between white and African American individuals with private insurance. However, our survey does suggest that Hispanics and other minorities (American Indians, Alaskan Natives, Asian Americans, and Hawaiian and Pacific Islanders) were more likely than whites to report access problems (data not shown).

Reports of not getting needed physician care were more frequent for privately insured and lower income individuals

Our survey also examines rates of patients reporting that they did not see a physician when they thought they should have. In 2009, Medicare beneficiaries (7 percent) were less likely than their privately insured counterparts (11 percent) to say that they should have seen a doctor for a medical problem in the past year but did not (Table 2B-1, p. 73). For those people who reported not getting care, fewer than 20 percent listed physician availability issues (e.g., getting an appointment time or finding a doctor) as the problem (not shown in table). The other reasons they gave included cost, low perceived seriousness of the problem at the time of the illness, and procrastination.

Race and income are related to reports of not getting needed care. Among Medicare beneficiaries, minorities (9 percent) were significantly more likely than whites (6 percent) to report not getting physician care when they thought they should have. Similarly, privately insured minorities (13 percent) were significantly more likely than privately insured whites (10 percent) to report not getting physician care when they thought they should have (Table 2B-2, p. 74). We also found that, for both Medicare and privately insured people, those with lower incomes were more likely to report that they did not see a physician when they thought they should have (not shown in table). This finding is consistent with much published research (Strunk and Cunningham 2002). Considering the recent downturn in the U.S. economy, concerns about out-of-pocket spending for health care are likely to increase.

Market area issues

While on a national level, our telephone survey does not find widespread physician access problems, certain market areas may be experiencing more access problems due to factors unrelated to Medicare—or even private—payment rates, such as relatively rapid population growth. In examining this market-area access issue, HSC compared physician access by geographic area, with particular attention to the difference between Medicare and private insurer fees in each area (Trude and Ginsburg 2005). This research found that, despite differences in Medicare and commercial payment rates across markets, the proportion of Medicare beneficiaries reporting problems with access to care did not vary based on differences in Medicare and private payer rates. In addition, privately insured people age 55 to 64 did not appear to gain better access to care relative to Medicare beneficiaries in markets with higher commercial payment rates. These findings suggest that developments in local health systems and markets may strongly influence access for both Medicare beneficiaries and the privately insured. Indeed, these conditions may affect beneficiary access as much as or more than Medicare payment levels.

Although our survey is not large enough to allow us to examine access by specific market areas, we are able to examine access by rural and urban areas. Within the Medicare sample, we found no statistical differences between rural and urban beneficiaries in their ability to get timely appointments and find new physicians. However, among the privately insured sample, we did find statistical differences in their ability to find new physicians. For example, rural privately insured individuals were more likely to report a "big problem" finding a specialist than urban privately insured individuals (see online Appendix A to this chapter, available at http://www.medpac.gov). Additionally, we found that rural Medicare beneficiaries had the same or better access than rural privately insured individuals.

This year, we also explored market-area access through beneficiary and physician focus groups in three areas (discussed later in this chapter). Although we found some variation, in all three areas, most physicians were accepting Medicare beneficiaries and beneficiary reports of access problems were uncommon.

Other national patient surveys show comparable results

Results from other patient surveys (conducted or sponsored by CMS, The Commonwealth Fund, HSC, and AARP) are analogous to the Commission's survey results on access to physician services. We summarize findings from these studies below.

The Consumer Assessment of Healthcare Providers and Systems for Medicare FFS (CAHPS®–FFS) is a large CMS-sponsored survey that asks assorted questions

related to the health care services FFS beneficiaries receive. In 2008, its most recent round, 87 percent of Medicare beneficiaries reported "always" or "usually" being able to schedule timely appointments for routine care. Also, 91 percent of beneficiaries reported that they "always" or "usually" were able to schedule an appointment with a specialist as soon as they wanted. The share of beneficiaries reporting major problems accessing physicians for routine and specialty care has remained below 6 percent since 2001. Although, generally speaking, patients with poorer health status were more likely to report problems, beneficiaries age 85 or older were least likely to report big problems. Considering the importance of tracking access to primary care specifically, the Commission suggests that CMS consider asking specifically about beneficiary access to primary care providers on the CAHPS–FFS survey, including primary care physicians, nurse practitioners, and physician assistants.

In a 2007 patient survey, the Commonwealth Fund found that, compared with people who have private insurance, Medicare beneficiaries age 65 or older reported fewer problems obtaining medical care, less financial hardship due to medical bills, and higher overall satisfaction with their health care (Davis et al. 2009). Among elderly Medicare beneficiaries, 10 percent said that their physician did not take their insurance, compared with 17 percent of those with employer coverage and 24 percent of those with individually purchased insurance. About 20 percent of elderly Medicare beneficiaries reported access problems for health care due to costs compared with 37 percent of people with employer-sponsored health insurance. Regarding perceived quality of care, 61 percent of elderly Medicare beneficiaries said that they received "excellent or very good" care, compared with 49 percent of those covered by employer-based plans and 48 percent of those with individually purchased insurance.[5]

HSC also reported household survey results on access to health care by type of insurance for 2007. Over the last decade, HSC has conducted three large household surveys funded by the Robert Wood Johnson Foundation. For 2007, HSC found that Medicare beneficiaries were significantly less likely to report delaying or not getting needed medical care than people with employer-sponsored private insurance and nongroup private insurance (Cunningham 2008). Although Medicare beneficiaries fared best, this survey found that access has generally worsened for all insurance types over the last decade.[6] In earlier work, HSC also examined patient-reported waiting times for appointments. From 1997 to 2003, they found that waiting times, in days, increased for both Medicare beneficiaries and privately insured individuals age 55 to 64. This finding held true for primary care and specialist appointments, but the research has not been updated since 2003. Although waiting times rose from 1997 to 2003, complaints about delaying care did not rise at the same pace, suggesting that patients may now expect longer waits for physician appointments (Trude and Ginsburg 2005).

AARP also conducted a patient survey in 2007, which found that Medicare respondents were less likely to encounter problems accessing physicians than privately insured people age 50 to 64 (Keenan 2007). For example, 68 percent of Medicare beneficiaries reported that they "never" had to wait longer than they expected for routine care, compared with 60 percent of privately insured respondents. The AARP survey also asked about patients' satisfaction with access to physicians. Among Medicare beneficiaries, 82 percent reported that they were "extremely satisfied" or "very satisfied" compared with 78 percent of privately insured individuals. Although this survey's sample size is smaller than both the Commission's and HSC's surveys, its results are consistent with the larger surveys.

Using a variety of methods, the Government Accountability Office also concluded that Medicare beneficiaries have stable access to physician services (Government Accountability Office 2009b). This study found that Medicare beneficiaries experienced few problems accessing physician services during a 2007–2008 study period. Furthermore, the proportion of beneficiaries who received physician services and the number of services per beneficiary served increased nationwide from 2000 to 2008.

Physician surveys show that most physicians accept Medicare patients

We also measure beneficiary access to physicians through information obtained in physician surveys, such as those conducted by HSC, the Commission, and the National Center for Health Statistics. For the most part, these surveys explore physicians' willingness to accept new patients by various insurance types, finding that most physicians are willing to accept some or all Medicare patients.

HSC's mail survey of physicians in 2008 found that most physicians are accepting all or most new Medicare and

privately insured patients in their practice (Boukus et al. 2009). Specifically, 74 percent of physicians reported that their practices accepted all or most new Medicare patients, and 87 percent reported accepting all or most new privately insured patients. (These percentages include practices with potentially low shares of Medicare patients, such as pediatrics.) Physicians' acceptance of new Medicaid patients was lower (53 percent) than for Medicare and privately insured patients. African American physicians were more likely than white physicians to accept new Medicaid patients. Physicians in rural areas were more likely than those in urban areas to accept new patients of all insurance types.

Boukus and colleagues also found that newer physicians were more likely to accept new Medicare patients than physicians who had been in practice longer. Additionally, employee physicians (compared with full or part owners) and physicians who are part of a group practice (compared with solo or two-physician practices) were more likely to accept all new Medicare patients. Physicians who classified themselves in surgical or medical specialties were more likely to accept all new Medicare and privately insured patients compared with the remaining internal medicine physicians—most, if not all, of whom practice primary care. Considering that the share of physicians selecting careers in office-based primary care is declining, this differential in access between primary care and specialty care is likely to widen for both Medicare and privately insured patients (Bodenheimer 2006).

The National Ambulatory Medical Care Survey (NAMCS)—a national survey of office-based physicians—also shows that over the last several years a large majority of physicians continue to accept some or all new Medicare patients. For 2007, among physicians with at least 10 percent of their practice revenue coming from Medicare, 92 percent accepted at least some new Medicare patients (Cherry 2009). By specialty, 88 percent of primary care physicians and about 94 percent of physicians in all other specialties accepted at least some new Medicare patients.[7]

The Commission's 2006 survey of physicians also asked about acceptance of new patients by insurance type (Medicare Payment Advisory Commission 2007b). Separating Medicare FFS from Medicare Advantage, and differentiating between HMO and non-HMO private insurance, we found that 80 percent of physicians accepted all or most new Medicare FFS patients; 86 percent of physicians accepted all or most new private, non-HMO patients; 65 percent of physicians accepted all or most new HMO patients; and 47 percent accepted all or most new Medicaid patients.

A different type of study—focused more on claims-processing indicators—also compares Medicare with private insurers. Conducted by the American Medical Association (AMA), the 2009 National Health Insurer Report Card shows that Medicare performed similar to or better than private insurers on several claims-processing measures, such as indicators for timeliness, transparency, and accuracy of claims processing (American Medical Association 2009). The report card noted that, although Medicare had higher rates of denied claims (4 percent) than several of the private insurers, Medicare does not require preauthorization for services, as do many private insurers.

Focus groups of beneficiaries and physicians report no major access problems

In addition to analysis of nationally based indicators of access to physician services, we also conducted focus groups with beneficiaries and physicians to gain further insight into access issues in different areas of the country. For this work, we conducted a series of 18 focus groups in three areas (Baltimore, Chicago, and Seattle). Participants totaled 99 Medicare beneficiaries and 64 physicians. Although focus groups are not designed to be nationally or even regionally representative, Medicare participants were recruited to include a range of participants representing different income level, race and ethnicity, and health status. Our physician focus groups also included a range of physicians from different practice sizes (from solo to large group practices), specialties, race and ethnicity, and patient populations. Overall, we found that access to physician services does not appear to be a major problem in any of these three locations, but one or more participants in each location reported some difficulties. Most physicians said that they were accepting new Medicare patients, but a few were not.

Beneficiary focus groups For the most part, beneficiaries in our focus groups stated that they had long-established relationships with a particular doctor or practice and have not recently needed to search for a new doctor. Most beneficiaries reported that they did not have to wait an unreasonable amount of time to get an appointment with their doctors, especially their primary care doctor. Several reported that, although they heard about primary care doctors not accepting new Medicare patients, they did not

experience a problem. Lower income beneficiaries in the focus groups appeared more likely than higher income individuals to encounter access problems.

Because the incidence of needing and looking for a specialist (for new health problems) is higher than that for primary care physicians, problems finding specialists and getting appointments with them were more frequently reported in our focus groups, compared with primary care physicians—with whom beneficiaries had long-standing relationships. (Recall that our annual telephone survey shows that only 6 percent of Medicare beneficiaries report needing to find a primary care physician (Table 2B-1, p. 73).) A few beneficiaries reported that, compared with their previous experiences in private insurance, they preferred having Medicare because the coverage seemed to work more smoothly. In more than one market area, however, beneficiaries under age 65 reported feeling that doctors questioned the extent of their disability and thus their Medicare eligibility.

Physician focus groups In the physician focus groups, we asked physicians about their willingness to accept new Medicare patients and their ability to get referrals for their patients. Although almost all the physicians in our focus groups were accepting new Medicare patients, a few were not. Most complained that Medicare's payment rates are low relative to private insurer payment rates. Some physicians reported that their offices limited the number of new Medicare patients that they accept each year. Some specialists emphasized the importance of maintaining Medicare revenue and accepting Medicare referrals in their practice. Some physicians in our focus groups indicated that they did not accept Medicare Advantage plans but did accept patients with traditional Medicare. Other physicians—even in the same city—reported that they had the opposite policy. Some physicians reported that they did not accept certain private insurance plans because of low payment rates and inability to negotiate higher rates. Medicaid was, by far, the least accepted insurance source among the physicians.

Psychiatry was the most frequently listed specialty for which physicians reported having difficulty finding referrals for their Medicare patients. Researchers have attributed this access problem primarily to Medicare's considerably higher beneficiary cost-sharing liability for outpatient psychiatric services, relative to other Part B services (Abrams and Young 2006, Slade et al. 2005). Psychiatrists may be unable to collect the full cost-sharing portion from patients or from Medicaid in some states. On this issue, the Congress recently lowered beneficiary cost sharing for outpatient psychiatric services to become equal to that of most other Part B services by 2014 as described in the text box on page 80. Note, however, that this policy change does not affect Medicare's allowed fee schedule rate for these services. Some observers may also attribute access problems to Medicare's allowed fee schedule payment rate for these services. Further research on Medicare's fee schedule valuation of these services may be helpful. Also, other research has found that psychiatrists are much less likely to accept new patients, regardless of insurance type, than other physicians (Boukus et al. 2009).

There was considerable agreement among physicians in our focus groups about their likes and dislikes regarding Medicare. The most frequently cited complaint about Medicare was that its payment rates were lower than private rates. Many physicians stated that Medicare did not compensate them sufficiently for the time they needed to spend with elderly patients with complex medical problems. Several physicians in one area expressed frustration with Medicare's coding issues and the billing system—especially the coding of longer physician visits—and cited anxiety about Medicare audits and reviews.

Almost all physicians reported that they liked the predictability and reliability of Medicare payment. Many also commented that they appreciated Medicare's lack of preapproval requirements, particularly for surgical procedures—allowing physicians to address patients' needs quickly. A third item that many physicians stated regarding their likes about Medicare was its reliable coverage for elderly and disabled patients. One physician said that he was appreciative that he did not have to worry about his elderly patients losing health insurance and not being able to come see him. Others also stated that they enjoyed treating the elderly patient population and found this age group intellectually stimulating.

The topic of "concierge care" was raised by participants in both the beneficiary and physician focus groups. In general, concierge care—also known as retainer-based care—is physician-based care (typically for primary care) in which patients are charged a membership fee in return for enhanced services. This model of care is associated with lower patient caseloads per physician. Many beneficiaries in our focus groups had heard of concierge care but most were not directly affected by it and did not report access problems resulting from it. Two beneficiaries who had recently signed up with concierge physicians reported that, although it was expensive, they liked it.

Payment policy changes for outpatient psychiatric services may improve patient access

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) phases out the higher cost-sharing liability that had been in place for outpatient psychiatric services since Medicare's inception. Starting in 2010, beneficiary cost sharing drops from 50 percent to 45 percent, then drops again in 2012 to 40 percent, in 2013 to 35 percent, and in 2014 to 20 percent—equal to that of most other Part B Medicare services.

Many experts and researchers have stated that this historic disparity in cost sharing between most other Part B services and outpatient psychiatric services created access problems for Medicare patients. Some mental health professionals may be unwilling to accept Medicare patients who do not have supplemental insurance that fully covers their cost sharing because of the challenges associated with collecting this portion from patients or from Medicaid in some states (Abrams and Young 2006, Slade et al. 2005). Several physicians in our focus groups (discussed on pp. 78–80 of this chapter) stated that finding psychiatrists for their Medicare patients can be difficult.

The MIPPA provision does not mean that psychiatrists and other eligible mental health professionals will be able to collect higher total amounts for their services as determined by the physician fee schedule. Rather, they will be able to collect larger shares of payments from Medicare and rely less heavily on copayments from patients (some of whom may have been unable to afford the cost sharing) and supplemental insurance (including Medicaid).

Regarding other work related to mental health care, the Commission is currently examining issues related to Medicare's prospective payment system for inpatient psychiatric care. ■

Alternatively, several beneficiaries stated that they would not want to pay the extra fees and would be unhappy if their physicians converted to concierge practices. None of the physicians in our focus groups was in a concierge practice, but one had former experience in one. Many of the physicians expressed concern about this model of care, but a small number of physicians thought it could be useful and compared it with medical home models.

Rates of physician participation and services paid on assignment are high

To supplement our data on the supply of physicians treating Medicare patients and beneficiaries' reported access to physician care, we examine assignment rates (the share of Medicare allowed charges for which physicians accept the assigned fee schedule amount as payment in full) and physician participation rates (the share of physicians and other health professionals with signed Medicare participation agreements who accept the fee schedule amount as payment in full). Our analysis of Medicare claims data shows that 99.5 percent of allowed charges for physician services were assigned in 2008 (Figure 2B-1); that is, for almost all allowed services that year, physicians agreed to accept the Medicare fee schedule amount as payment in full for the service. The assignment rate has held steady at more than 99 percent since 2000.

The high rate of assigned charges reflects the fact that most physicians who bill Medicare do so as participating physicians. For 2009, 95 percent of physicians, limited license practitioners, and nonphysician practitioners who billed Medicare had participation agreements with Medicare. Participating physicians agree to accept assignment on all allowed Medicare claims in exchange for a 5 percent higher payment on allowed charges. Participating physicians also receive nonmonetary benefits, such as being able to receive payments directly from Medicare (less the beneficiary cost-sharing portion) rather than having to collect the total amount from the beneficiary. This arrangement is a major convenience for many physicians. In fact, we note that in AMA's 2009 National Health Insurer Report Card, Medicare performed similar to or better than private insurers on several claims-processing measures, such as indicators for timeliness,

transparency, and accuracy of claims processing (American Medical Association 2009). Participating physicians also have their name and contact information listed on Medicare's website and they have the ability to electronically verify a patient's Medicare eligibility and supplemental insurance status. Participation agreements, however, do not require physicians to take Medicare patients.

While 97 percent of allowed charges in 2008 were for services provided by participating physicians, another 2 percent were for services provided by nonparticipating physicians who decided to accept assignment. Only 0.5 percent of allowed charges were for services provided by nonparticipating physicians who did not accept assignment.

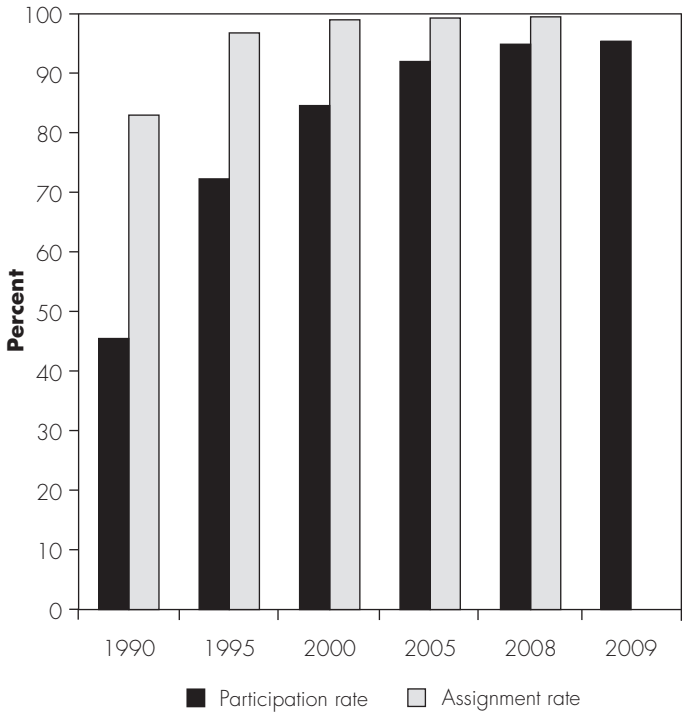
Volume growth does not reveal access problems but highlights sustainability, pricing, and equity concerns

Interpreting increases and decreases in service volume growth as an indicator of payment adequacy is complex. For example, decreases in volume could signify price inadequacy if physicians were reluctant to offer such services based on their Medicare payment. However, our evidence indicates that volume decreases are more likely to be due to other factors, such as general changes in practice patterns. For example, the volume of coronary artery bypass grafting has been declining as other interventions substitute for the procedure. Increases in volume may signal overpricing if physicians favor certain services because they are exceedingly profitable; similarly, other factors—including population changes, disease prevalence, changes in Medicare benefits, shifts in the site of care, technology, and beneficiaries' preferences—can also explain volume increases. As an example, procedures for injecting pharmacologic agents into the eye have increased in volume in recent years as therapies have emerged for treating macular degeneration. Another confounding factor is that the volume of services sometimes increases when payment rates decline (Codespote et al. 1998). The possibility of such a response—known as a behavioral or volume offset—makes it particularly difficult to interpret volume increases by themselves as an indicator of payment adequacy.

Volume growth gives rise to other concerns expressed by the Commission and others about the future of Medicare. These concerns include the fiscal sustainability of the Medicare program, the inequity of a payment system that allows some physicians to generate volume and revenue more readily than others, and the mispricing of services in the physician fee schedule. We discuss these issues later in the chapter.

FIGURE 2B–1

Participation and assignment rates have grown to high levels, 1990–2009



Note: Participation rate is the percentage of physicians and other professionals with signed Medicare participation agreements. Assignment rate is the percentage of Medicare allowed charges for which physicians and other health professionals accept the assigned fee schedule amount as payment in full. The assignment rate for 2009 is not shown; it requires calculations from claims not yet available.

Source: Ways and Means Greenbook (2004), unpublished CMS data, and MedPAC analysis of Medicare claims for a 5 percent random sample of Medicare beneficiaries.

In 2008, the volume of physician services used per Medicare beneficiary continued to grow. For this analysis, we used claims data for 2003 through 2008 and calculated per beneficiary growth in the units of service furnished by physicians and other professionals billing under Medicare's physician fee schedule. We then weighted the units of service by each service's relative value units (RVUs) from the physician fee schedule. The result is a measure of growth that accounts for changes in both the number of services and the complexity, or intensity,

of those services. We thus distinguish growth in volume from growth in units of service: volume growth includes changes in intensity, whereas unit-of-service growth does not. Compared with analyzing growth in spending, measuring growth in volume removes the effects of price changes.

Across all services, volume per beneficiary grew 3.6 percent in 2008 (Table 2B-3). For each broad category of service—evaluation and management (E&M), imaging, major procedures, other procedures (nonmajor), and tests—growth rates varied but were all positive. Services in the "tests" category grew the most: from 2007 to 2008, they increased 4.5 percent. Growth rates for other categories were 4.3 percent for other procedures, 3.5 percent for E&M, 3.3 percent for imaging, and 2.7 percent for major procedures.

In contrast to volume growth for the broad service categories, some of the subcategories of services saw decreases. The volume decrease in coronary artery bypass grafts continues a trend in recent years and likely represents substitution of less invasive services for this procedure. The volume decrease in colonoscopy is more difficult to interpret. We note that Medicare beneficiaries use different types of services for screening, diagnosis, and treatment of diseases of the colon. We will monitor these services for signs of changes in utilization. In the case of the two categories of MRI studies—MRI of the brain and MRI of other parts of the body, we make two observations about the decreases in the volume of these services. First, for both categories, the number of services per beneficiary increased. Second, the intensity of services decreased—that is, average RVUs per service fell. The decreases in intensity occurred because of shifts in utilization from studies done with contrast material to studies done without contrast material.

Other subcategories saw increases in volume per beneficiary, with some of the increases raising questions about necessity. Imaging services in the "Advanced—computed tomography (CT): other" category are one example. These services grew at an average annual rate of 12.6 percent from 2003 to 2007 and by another 4.6 percent from 2007 to 2008.[8] This growth has accompanied dramatic increases in CT availability, raising questions about the costs and benefits of the expansion (Baker et al. 2008). Outpatient rehabilitation, under other procedures, is another service that has seen rapid growth in volume. From 2003 to 2007, the volume of these services per beneficiary grew an average 11.7 percent per year. From 2007 to 2008, growth was another 10.3 percent. Because of concerns about growth in spending for these services, limits—known as "therapy caps"—were established as part of the Balanced Budget Act of 1997.[9] However, much of the growth in 2008 occurred in services eligible for an exception to the caps.[10] Under major procedures, the "orthopedic—other" category is a third example of services with rapid volume growth. From 2003 to 2007, service volume went up by an average of 7.2 percent and from 2007 to 2008 it went up by 8.1 percent. While this category includes a somewhat heterogeneous mix of services, much of the growth here is in spine surgery, a type of procedure that has prompted questions about effectiveness (Abelson 2008).

Quality of care: Most ambulatory care quality measures remained stable or improved from 2006 to 2008

Our analysis of Medicare claims data shows that ambulatory care quality, by most measures, was stable or showed improvement. Using a set of indicators developed by the Commission, the Medicare Ambulatory Care Indicators for the Elderly (MACIEs), we measured changes over time in the provision of necessary acute and follow-up care to beneficiaries in FFS Medicare with certain acute and chronic-disease diagnoses that are prevalent in the Medicare elderly population, and we measured rates of potentially avoidable hospitalizations for five chronic conditions. Online Appendix B to this chapter describes development of the MACIEs in more detail and online Appendix C to this chapter lists the 38 indicators.

Most quality indicators improved or were stable from 2006 to 2008

Comparing the indicators in 2008 with those in 2006, we find that most remained stable or improved (Table 2B-4, p. 84). Among the 38 MACIE measures, 19 showed statistically significant improvement and 14 showed no statistically significant change. This finding indicates that beneficiaries with the selected conditions were at least as likely (or more likely) in 2008 as in 2006 to receive the clinically indicated services for their condition and, in most cases, avert potentially avoidable hospitalizations related to their condition. Further, we see improvements in the potentially avoidable hospitalization outcome measures for diabetes, coronary artery disease, and congestive heart failure that are correlated with improvements in performance on process measures for the same conditions.

TABLE 2B–3

Use of physician services per fee-for-service beneficiary continues to increase

Type of service	Change in units of service per beneficiary: Average annual 2003–2007	Change in units of service per beneficiary: 2007–2008	Change in volume per beneficiary: Average annual 2003–2007	Change in volume per beneficiary: 2007–2008	Percent of total volume
All services	**3.5%**	**3.1%**	**4.9%**	**3.6%**	**100.0%**
Evaluation and management	**1.5**	**2.2**	**3.2**	**3.5**	**42.5**
Office visit—established patient	1.6	1.9	3.0	3.2	18.2
Hospital visit—subsequent	1.3	2.0	2.4	3.2	8.5
Consultation	0.1	1.2	2.5	2.2	5.5
Emergency room visit	1.3	3.0	3.6	5.2	2.9
Nursing home visit	2.6	4.1	9.7	5.3	2.2
Hospital visit—initial	0.4	2.6	0.8	3.0	2.0
Office visit—new patient	1.7	2.4	1.9	2.7	1.7
Imaging	**4.6**	**2.8**	**8.3**	**3.3**	**15.8**
Advanced—CT: other	10.3	5.1	12.6	4.6	2.4
Echography—heart	5.8	4.2	6.9	4.6	1.9
Standard—nuclear medicine	4.1	–0.8	6.3	0.5	1.9
Advanced—MRI: other	10.0	1.2	10.6	–0.1	1.8
Standard—musculoskeletal	3.5	0.9	3.4	1.0	1.0
Advanced—MRI: brain	5.5	2.0	5.1	–1.9	0.9
Echography—other	9.8	6.1	10.8	7.1	0.9
Imaging/procedure—other	12.3	6.3	14.6	10.6	0.7
Standard—breast	8.9	5.7	5.2	7.4	0.7
Standard—chest	0.9	2.5	1.3	2.7	0.6
Echography—carotid arteries	5.1	2.6	8.3	4.6	0.6
Advanced—CT: head	6.9	5.1	8.5	4.4	0.6
Major procedures	**2.5**	**0.4**	**3.1**	**2.7**	**8.6**
Cardiovascular—other	–0.4	–0.1	1.2	2.1	1.8
Orthopedic—other	6.6	7.6	7.2	8.1	1.2
Knee replacement	6.6	2.3	7.8	2.9	0.7
Coronary artery bypass graft	–7.6	–5.9	–7.7	–6.2	0.5
Coronary angioplasty	–1.0	1.2	–1.1	0.9	0.4
Explore, decompress, or excise disc	5.0	5.1	5.6	5.5	0.4
Hip replacement	2.1	1.9	3.3	2.6	0.4
Hip fracture repair	–0.2	–0.1	1.1	0.8	0.3
Pacemaker insertion	4.4	5.9	3.7	1.8	0.3
Other procedures	**6.5**	**5.7**	**6.6**	**4.3**	**21.3**
Skin—minor and ambulatory	3.7	3.6	4.8	3.5	3.7
Outpatient rehabilitation	11.3	9.5	11.7	10.3	2.8
Radiation therapy	3.0	–0.3	8.6	4.7	2.3
Minor—other	17.4	5.1	9.6	7.2	2.2
Cataract removal/lens insertion	1.3	0.1	1.7	0.5	1.5
Minor—musculoskeletal	7.9	4.4	9.5	5.5	1.4
Colonoscopy	2.1	–1.3	1.9	–1.4	1.0
Eye—other	11.3	10.3	7.5	2.3	0.9
Cystoscopy	2.5	0.6	5.4	1.0	0.5
Upper gastrointestinal endoscopy	2.7	1.9	2.7	2.3	0.5
Tests	**3.3**	**2.0**	**6.2**	**4.5**	**5.0**
Other tests	4.8	0.7	8.9	4.1	2.2
Electrocardiogram	1.7	1.3	1.7	2.5	0.6
Cardiovascular stress tests	4.9	1.3	5.4	2.7	0.6
Electrocardiogram monitoring	4.7	7.7	3.3	3.6	0.2

Note: CT (computed tomography), MRI (magnetic resonance imaging). Volume is measured as units of service multiplied by each service's relative weight (relative value units) from the physician fee schedule. To put service use in each year on a common scale, we used the relative weights for 2008. For billing codes not used in 2008, we imputed relative weights based on the average change in weights for each type of service. Some low-volume categories and services are not shown but are included in the summary calculations. One such category includes all positron emission tomography services that would otherwise appear in disparate other categories.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

TABLE 2B–4

Most ambulatory care quality indicators improved or were stable from 2006 to 2008

	Number of indicators			
Indicators	**Improved**	**Stable**	**Worsened**	**Total**
All	19	14	5	38
Anemia	3	1	0	4
CAD	3	1	0	4
Cancer	0	3	4	7
CHF	7	1	0	8
COPD	1	0	1	2
Depression	0	1	0	1
Diabetes	4	3	0	7
Hypertension	0	1	0	1
Stroke	1	3	0	4

Note: CAD (coronary artery disease), CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease).

Source: MedPAC analysis of Medicare Ambulatory Care Indicators for the Elderly (MACIE) from the Medicare 5 percent Standard Analytic Files.

We found a statistically significant decline in 5 of the 38 quality indicators from 2006 and 2008. First, we found a small decline (about 0.5 percentage point) in the breast cancer screening rate (64.8 percent) for female beneficiaries age 65 to 74. This change is consistent with breast cancer screening rates for Medicare managed-care enrollees, which decreased from 69.5 percent in 2006 to 68.0 percent in 2008 (National Committee for Quality Assurance 2009). Second, we found a relatively larger decrease in the rate for follow-up mammography for beneficiaries who had a diagnosis of breast cancer within the preceding 12 months.[11] Third, we observed a small (less than 2 percentage points) decrease in the rate of recommended chest X-rays for beneficiaries with an initial diagnosis of breast cancer. Fourth, we identified a small decline in the rate of colonoscopies for beneficiaries with a first-time diagnosis of iron-deficiency anemia (a potential symptom of colon cancer). Last, we found a small increase in the rate of potentially preventable hospitalizations for beneficiaries diagnosed with chronic obstructive pulmonary disease (COPD). COPD can often be controlled in an outpatient setting, so a rise in the hospitalization rate for exacerbations of COPD may reflect a decline in the quality of outpatient care (Agency for Healthcare Research and Quality 2007).

Most measures of potentially avoidable hospitalizations improved or were stable from 2006 to 2008

Six MACIEs measure the occurrence of potentially avoidable hospitalizations or emergency department visits for selected chronic conditions. Three of these measures improved, two remained stable, and one worsened (hospitalizations for beneficiaries with COPD, discussed above). The three measures that significantly improved from 2006 to 2008 were the percentage of beneficiaries diagnosed with unstable angina who had multiple emergency department visits during the year, the percentage of beneficiaries with diabetes who were admitted to a hospital for serious long-term complications of that condition (e.g., lower extremity amputation), and the percentage of beneficiaries with congestive heart failure who had hospitalizations related to heart failure. Inpatient admission rates were stable for beneficiaries with diabetes or with hypertension who were admitted for treatment of serious short-term complications of those conditions.

We found that, for several conditions, the declines in potentially avoidable hospitalizations occurred concurrently with increases in the use of other clinically indicated services for the same condition. For example, for diabetes we found a decrease in the rate of diabetes-related hospitalizations over the same time period that we observed statistically significant increases in the use of diagnostic testing (such as lipid and hemoglobin testing) and follow-up visits for beneficiaries diagnosed with diabetes.

Medicare payments and providers' costs

To assess Medicare payments and providers' costs, we compare Medicare's fee schedule payments to private insurers' payments and examine forecasts for input cost changes. We cannot look at financial performance of physicians directly because physicians are not required to report their costs to Medicare, as are other providers such as hospitals and home health agencies.

Ratio of Medicare to private insurer physician fees has remained relatively stable

Another measure of Medicare payment adequacy examines the trend in Medicare's allowed physician fees (including patient cost sharing) relative to private insurer allowed fees.[12] In the early to mid-1990s, Medicare payment rates averaged about two-thirds of commercial payment rates for physician services, but since 1999

Medicare rates consistently have been near 80 percent of commercial rates. For 2008, Medicare's payments for physician services are at 78 percent of commercial rates when averaged across all physician services and geographic areas (Figure 2B-2). We base this analysis on a data set of paid claims for two large national private insurers.[13] In a comparison of the two most recent years, the 2008 rate is slightly lower (about 1 percentage point) than it was for 2007. For this year's report, we refined our analysis methodology, which resulted in lower ratios of Medicare to private rates by 1 to 2 percentage points in the years 2004–2008.[14]

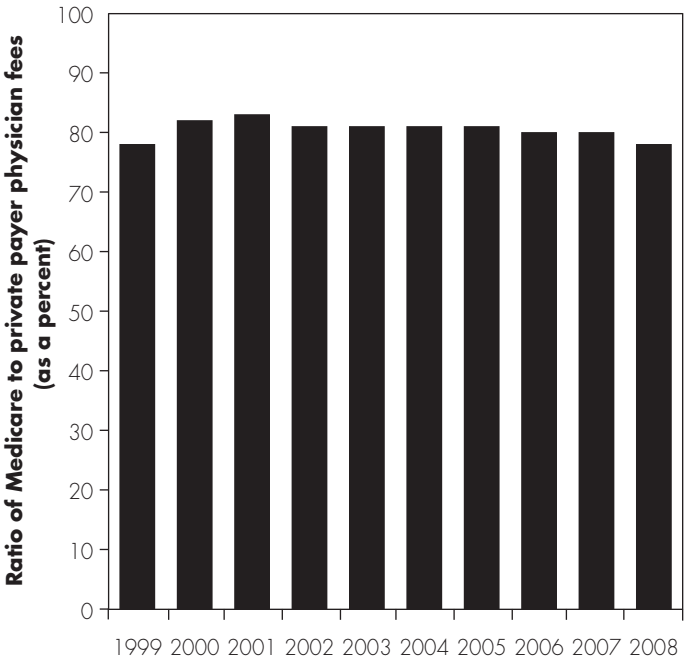
Medicare's payment rates for E&M services are closer to private payers' rates—about 82 percent on average in 2008. We continue to see the effects of decline in Medicare payment rates for the broad category of imaging services due to a provision in the Deficit Reduction Act of 2005 that capped fee schedule imaging rates at rates from the outpatient prospective payment system and changed the calculation of practice expenses. If our Medicare-to-private analysis excluded imaging services, the 2008 ratio would have been about 2 percentage points higher—that is, the overall ratio would be about 80 percent for nonimaging services.

It may also be useful to compare Medicare fees with national preferred provider organization (PPO) rates because most commercially insured individuals (nearly two-thirds) are in PPO arrangements. This comparison may better represent the prevailing commercial rates that physicians face relative to Medicare. Using a subset of the data included in our overall analysis, we calculate that Medicare's rates for physician services average about 80 percent of commercial PPO rates.

In considering how commercial payment rates may affect access for Medicare beneficiaries, we refer to research conducted by HSC, cited earlier in this chapter. This research found that the proportion of Medicare beneficiaries reporting problems with access to care in markets with the widest payment rate gaps did not vary significantly from the proportion reporting problems in markets with more similar payment rates (Trude and Ginsburg 2005). In addition, privately insured individuals age 55 to 64 did not appear to gain better access to care relative to Medicare beneficiaries in markets with higher commercial payment rates. These findings suggest that developments in local health systems and markets may strongly influence access for both Medicare beneficiaries and the privately insured. These conditions may affect beneficiary access as much as or more than Medicare payment levels.

FIGURE 2B–2

Ratio of Medicare to private payer physician fees is stable



Note: Due to a refinement in our analysis methodology, results presented here for years 2004–2007 are slightly different from those published in previous MedPAC reports. Fee comparisons are based on allowed charges.

Source: Direct Research, LLC, for MedPAC for 1999–2003 data. MedPAC analysis for 2004–2008 data.

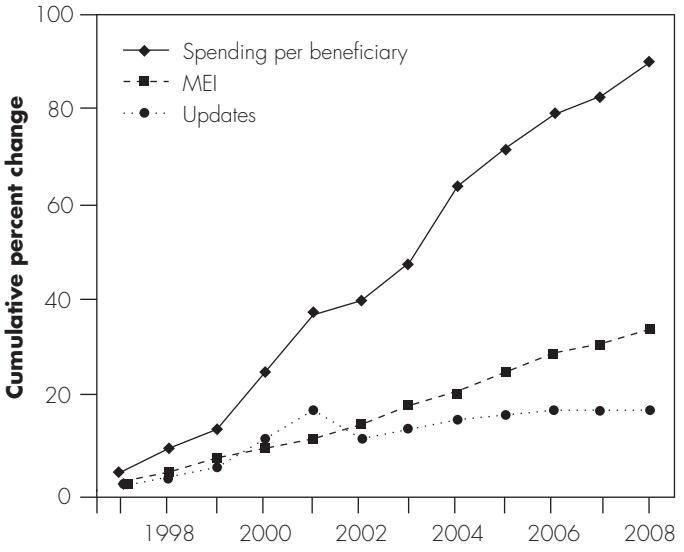
Input costs for physician practices are expected to increase in 2011

For 2011, CMS forecasts that input prices for physician services will increase by 2.1 percent.[15] This forecast does not include an adjustment for expected productivity increases. In contrast, CMS's 2011 forecast of the Medicare Economic Index (MEI)—a measure of changes in input prices for physician services, adjusted for productivity growth in the national economy—is 0.9 percent. For these forecast estimates, CMS collects from various data sets and surveys. Additionally, CMS calculates a weighted average of expected input price changes from survey data collected by the AMA in 2000.

Medicare's total payments to physicians have increased faster than both the MEI and updates to the fee schedule's

FIGURE 2B–3

Volume growth has raised spending faster than input prices and the updates



Note: MEI (Medicare Economic Index).

Source: 2005 and 2009 trustees' reports and data from Office of the Actuary.

conversion factor (Figure 2B-3). Over the first 12 years of the SGR policy (1997–2008), the updates rose 17 percent cumulatively while the MEI rose 34 percent cumulatively. However, examining these two rates ignores volume growth and its effect on physician revenues. Over the same 12-year period, Medicare spending for physician services—per beneficiary—increased by 90 percent. Volume growth accounts for the difference between the updates and spending growth, and physician revenues from this spending growth are a function of volume growth and fee schedule updates.

How should Medicare payments change in 2011?

In consideration of the expected input cost growth described above and our analysis of other payment adequacy indicators, the Commission recommends a modest update for physician services in 2011. We summarize this analysis and recommendation below.

Update recommendation

Our analysis of the most recently available data finds that, overall, Medicare payments for physician services are adequate. Access, supply, quality, and volume measures suggest that most Medicare beneficiaries are able to obtain physician services with few or no problems. Certain market areas, however, may be experiencing more access problems due to factors unrelated to Medicare—or even private—payment rates, such as relatively rapid population growth. Although a relatively small share of beneficiaries report major problems finding a primary care physician, these beneficiaries' experiences are very concerning. The Commission has made recommendations in previous reports to promote primary care services through targeted payment increases and the testing of medical home models of care.

For this report, we recommend that the Congress change current law to update the physician fee schedule conversion factor for 2011 by a moderate amount—1.0 percent. In making this update recommendation, the Commission takes into account three factors that summon the need to maintain cost pressures. First, the Commission strongly promotes the principle that Medicare's payment systems should encourage efficiency in the provision of Medicare services. Competitive markets demand continual efficiency improvements from the workers and firms who pay the taxes used to finance Medicare. Maintaining cost pressure is a key to achieving efficiency improvements. A second consideration that calls for constraint is the impact on beneficiaries' out-of-pocket spending liability. Updates for physician services carry with them increases to beneficiaries' cost-sharing and premium amounts. Third, the Medicare program faces fiscal sustainability problems, which require committed efforts to resolve if Medicare spending growth is to be slowed.

RECOMMENDATION 2B

The Congress should update payments for physician services in 2011 by 1.0 percent.

RATIONALE 2B

Our analysis of the most recently available data finds that, overall, Medicare payments for physician services are adequate. Access, supply, quality, and volume measures suggest that most Medicare beneficiaries are able to obtain physician services with few or no problems. In our 2009 patient survey, Medicare beneficiaries (age 65 or older) were more likely to report better access to physicians than privately insured individuals (age 50 to

64). We recommend that the Congress change current law to update the physician fee schedule conversion factor for 2011 by a moderate amount—1.0 percent. In addition, we reaffirm our previous recommendation to increase payments for primary care services when provided by practitioners who focus their practice on primary care (see text box, pp. 88–89).

IMPLICATIONS 2B

Spending

- Relative to current law, this recommendation is estimated to increase federal program spending by more than $2 billion in the first year and by more than $10 billion over five years. Enactment of any positive update for 2011 would substantially increase Medicare spending relative to current law, because current law under the SGR system calls for negative updates from 2010 through at least 2015.

Beneficiary and provider

- Relative to current law, the update recommendation would increase Part B premiums and coinsurance liability amounts. Payment increases for physician services would maintain provider willingness to serve Medicare patients and thus beneficiary access to their services.

Accuracy and equity of payment for physician services

The Commission has consistently raised concerns about mispricing of services in the physician fee schedule and the inequity of a payment system that allows some physicians to generate volume and revenue more readily than others. These issues have strong implications for the sustainability of Medicare and—over the long run—the mix of physicians serving Medicare beneficiaries.

- ***Mispricing.*** In previous work, the Commission made recommendations on improving the process through which CMS reviews the fee schedule's relative values for accuracy (Medicare Payment Advisory Commission 2006). Since then, CMS and the AMA Specialty Society Relative Value Scale Update Committee have improved the review process. However, there are still reasons for CMS to adopt our recommendations. For example, many procedures have never been reexamined to determine whether the average time and intensity of effort necessary to perform them has decreased as a result of advances in technology, technique, and other factors. When such efficiency gains are achieved, the work value for the affected services should decline accordingly, and—through application of budget-neutrality requirements—the values for all other services would increase (assuming all else equal). But because of the problems with the review process, categories of services without new procedures—such as primary care—become undervalued over time and thus risk being underprovided. The converse—that overvalued services may be overprovided—is also a concern.

- ***Equity.*** The physician fee schedule—a FFS payment system—creates two mechanisms for payment inequity among physicians. First, it rewards physicians who increase the volume of services they provide regardless of the services' benefits, with the potential—under the SGR system—for across-the-board reductions in fees for all services and all physicians. Second, the fee schedule establishes considerable differences in physician compensation. That is, for a given amount of a physician's time, differences in payment raise questions about whether they are consistent with the difficulty of furnishing the service. Furthermore, the Commission has raised questions about whether the basis and process for valuing physician services needs to be revised.

For future work, the Commission—while not determining RVUs—will continue to address these issues. As an example, we will consider the validity of estimates of the typical amount of time a physician spends furnishing the services billable under the physician fee schedule. These time estimates explain much of the variation in the fee schedule's payments for physician work. However, questions about the estimates have been raised in research for CMS and the Assistant Secretary for Planning and Evaluation (Cromwell et al. 2006, Cromwell et al. 2007, McCall et al. 2006). In addition, the Government Accountability Office found that the fee schedule does not adequately account for efficiencies occurring when a physician furnishes multiple services for the same patient on the same day (Government Accountability Office 2009a). The Commission will investigate the availability of data—or approaches to collecting data—that could substitute for the time estimates. Futher, we will explore whether expanding the unit of payment through packaging or bundling would improve payment accuracy and encourage more efficient use of services. ■

Previous Commission recommendation on a fee schedule adjustment for primary care

In 2008 and again in 2009, the Commission recommended a fee schedule adjustment to promote primary care. Through budget-neutral payment increases for primary care services, the recommendation redistributes fee schedule payments toward selected services furnished by primary care physicians and other health professionals who focus their practice on providing primary care, such as advanced practice nurses and physician assistants.

This recommended fee schedule adjustment would signal a major change in the purpose of the physician fee schedule. Currently, the fee schedule is intended only to account for differences in resource costs among services. Using the fee schedule as a vehicle for promoting primary care would be a very different role for the payment system. Instead of solely accounting for services' individual resource costs, a payment system that included an adjustment for primary care would place greater value on the services needed to achieve a reformed delivery system. Following is the recommendation made in the Commission's June 2008 and March 2009 reports:

The Congress should establish a budget-neutral payment adjustment for primary care services billed under the physician fee schedule and furnished by primary-care-focused practitioners. Primary-care-focused practitioners are those whose specialty designation is defined as primary care and/or those whose pattern of claims meets a minimum threshold of furnishing primary care services. The Secretary would use rulemaking to establish criteria for determining a primary-care-focused practitioner.

A fee schedule adjustment for primary care would help overcome the undervaluation of primary care services and help ensure beneficiaries' access to primary care services and practitioners. Because primary care is essential for a well-functioning health care delivery system, the Commission considers it important to increase its value in Medicare. If commercial insurers, Medicaid programs, and other payers use Medicare's physician fee schedule as a basis for their payment rates, the fee schedule adjustment could promote primary care throughout the health care system. In addition, the fee schedule adjustment would complement other recent, budget-neutral policy changes implemented through regulation:

(continued next page)

Previous Commission recommendation on a fee schedule adjustment for primary care (cont.)

- For 2007, CMS's five-year review—a review of the fee schedule's relative values for physician work—resulted in payment increases for most primary care services.
- Also for 2007, CMS changed its method for determining the relative value of a fee's practice expense component and started a four-year transition to the new values. This methodologic refinement—intended to improve payment accuracy—resulted in increased practice expense values for some types of services, including primary care.
- For 2010, CMS no longer recognizes the billing codes for consultation services. To make the change budget neutral, the agency has allocated the work relative values for consultations to some primary care services—office visits and initial nursing facility visits—and to initial hospital visits.
- For 2010, CMS has started a four-year transition to practice expense relative values that incorporate data from the Physician Practice Information Survey and that account for an increase in the utilization rate for expensive diagnostic equipment.[16] These changes have decreased practice expense relative values for some services and increased them for other services, including primary care services.

When fully implemented, the 2007 and 2010 policy changes could have an important effect on payments. Two caveats deserve consideration, however. First, the increases are limited in how much they would redistribute payments compared with the fee schedule adjustment the Commission recommends. They apply to the primary care services billed by all physicians, not just the primary care services furnished by practitioners who have focused their practices on primary care. Second, if the regulatory changes are altered, their effects could diminish. Comparing payment rates in 2006 with payment rates in 2010, the rates for primary care services would rise by 17.7 percent. The increases in 2010 are a large proportion of that total. The change in payment for consultations accounts for 3.1 percentage points of the increase. The practice expense changes account for 2.8 percentage points of the increase. ■

Endnotes

1 Physicians and other providers may be registered with Medicare but not actively billing Medicare. A Commission analysis of claims for 2006 shows that approximately 570,000 physicians billed Medicare. More recent data on the number of physicians billing Medicare are unavailable because of problems stemming from conversion to new provider identifier numbers, which occurred in 2007 to comply with the Health Insurance Portability and Accountability Act.

2 See http://www.medpac.gov/documents/MedPAC_Payment_Basics_09_Physician.pdf.

3 The 2009 survey included an oversample of African Americans, Hispanics, and other minorities—including American Indians, Alaskan Natives, Asian Americans, and Hawaiian and Pacific Islanders. All respondents had the opportunity to take the survey in English or Spanish.

4 Within that population, our survey results do not distinguish Medicare FFS enrollees from those in Medicare Advantage (MA) plans because of the technical difficulty in obtaining reliable self-identification of FFS or MA enrollment from surveyed individuals. Similarly, we do not distinguish by type of private coverage among the non-Medicare population in our survey.

5 Although the sample size of Commonwealth's survey makes it difficult to draw definitive conclusions about Medicare beneficiaries under the age of 65, results showed that these disabled beneficiaries reported access problems more frequently than elderly Medicare beneficiaries and privately insured individuals. Further study on access issues for disabled Medicare beneficiaries is needed to understand the circumstances driving these results, which are consistent with previous research findings (Briesacher et al. 2002).

6 Exact comparisons between HSC's surveys and the Commission's surveys are difficult because of differences in questions and respondent ages. For example, HSC's survey includes people of all ages, whereas the Commission's survey is limited to people age 50 or older. Also, the HSC survey does not specifically ask about access to physician care; instead, it focuses on access to medical care more generally.

7 For these analyses, we excluded certain types of specialties that do not typically serve most Medicare beneficiaries, such as all pediatric specialties, obstetrics, and medical genetics. Physicians with specialties of anesthesiology, radiology, and pathology are excluded by the NAMCS sampling frame, which focuses on office-based physicians.

8 The 2008 growth rate for these services includes—but is not limited to—rapid growth in CT-guided radiation therapy.

9 A more detailed description of the therapy caps can be found at www.medpac.gov/documents/MedPAC_Payment_Basics_09_OPT.pdf.

10 Some growth in the volume of outpatient therapy may be due to enforcement of a compliance threshold for inpatient rehabilitation facilities known as the "60 percent rule" (Medicare Payment Advisory Commission 2009)

11 Medicare coding requirements changed for mammography claims between 2006 and 2007. This change may have played a role in the decline we detected in our data analysis.

12 Although allowed amounts include patient cost-sharing liabilities, they do not include balancing billing amounts that would exceed the fee schedule amounts.

13 Our analysis relies on data from two national insurers, but—like all insurers—they face different market conditions in different areas. In a particular area, for example, there may be one dominant insurer that is better able to negotiate lower prices with providers, while other insurers have to pay higher rates. Although the data we use for our analysis from the two national insurers have a wide and diverse geographic distribution, we may not be able to fully capture the variation in private payment rates in different areas that results from local competitive circumstances.

14 The method used for the comparison involves calculating a price index for the different types of private plans present in the data that are the basis of our analysis—HMO, point of service, preferred provider organization (PPO), and indemnity. Each price index is a weighted average of service-level price comparisons between Medicare and private payment rates, using Medicare's volume in each service as the weight. The plan-specific estimates are then weighted based on the Kaiser Family Foundation and Health Research and Educational Trust yearly estimates of private enrollment in each type of plan for 2008 (Kaiser Family Foundation and Health Research and Educational Trust 2009). To address enrollment in high-deductible health plans (HDHPs), we classified them as PPOs for enrollment distribution and payment rate purposes, because health plan industry sources indicate that 90 percent of HDHP enrollees are offered these options off a PPO "platform."

15 This input cost forecast includes an estimated 2.2 percent increase in physician compensation (physicians' wages and benefits) and a 2.0 percent increase in practice expense costs. CMS updates these forecasts quarterly. We used the forecasts dated October 16, 2009.

16 In 2010, CMS will also conclude the four-year transition to the new method for calculating practice expense.

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